FORM APPROVED
OMB NO. 0960-0431

RESIDUAL PHYSICAL FUNCTIONAL CAPACITY ASSESSMENT

CLAIMANT:	SOCIAL SECURITY NUMBER:
NUMBERHOLDER (IF CDB CLAIM):	

PRIMARY DIAGNOSIS:	RFC ASSESSMENT IS FOR:
SECONDARY DIAGNOSIS:	☐ Current Evaluation ☐ Date Last Insured: _____ (Date) ☐ Date 12 Months After Onset: _____ (Date)
OTHER ALLEGED IMPAIRMENTS:	☐ Other (Specify): _____

Paperwork/Privacy Act Notice: The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and other agencies.

TIME IT TAKES TO COMPLETE THIS FORM: We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. If you have comments or suggestions on how long it takes to complete this form or on any other aspect of this form, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235, and to the Office of Management and Budget, Paperwork Reduction Project (0960-0431), Washington, D.C. 20503.

I. LIMITATIONS:

For Each Section A - F

→ Base your conclusions on **all evidence** in file (clinical and laboratory findings; symptoms; observations; lay evidence; reports of daily activities; etc.).

→ Check the blocks which reflect your **reasoned judgment.**

→ Describe how the **evidence substantiates your conclusions.** (Cite specific clinical and laboratory findings, observations, lay evidence, etc.).

→ Ensure that you have requested:

- Apropriate treating and examining source statements regarding the individual's capacities (DI 22505.000ff. and DI 22510.000ff.) and that you have given appropriate **weight to treating source conclusions**. (See Section III.)
- Considered and responded to **any alleged limitations imposed by symptoms** (pain, fatigue, etc.) attributable, in your judgment, to a medically determinable impairment. Discuss your assessment of symptom - related limitations in the explanation for your conclusions in A - F below. (See also Section II.)
- Responded to all allegations of physical limitations or factors which can cause physical limitations.

→ **Frequently** means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous). **Occasionally** means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

A. EXERTIONAL LIMITATIONS

☐ None established. (Proceed to section B.)

1. **Occasionally** lift and/or carry (including upward pulling) (maximum)—when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

   ☐ less than 10 pounds
   ☐ 10 pounds
   ☐ 20 pounds
   ☐ 50 pounds
   ☐ 100 pounds or more

2. **Frequently** lift and/or carry (including upward pulling) (maximum)—when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

   ☐ less than 10 pounds
   ☐ 10 pounds
   ☐ 25 pounds
   ☐ 50 pounds or more

3. Stand and/or walk (with normal breaks) for a total of—

   ☐ less than 2 hours in an 8-hour workday
   ☐ at least 2 hours in an 8-hour workday
   ☐ about 6 hours in an 8-hour workday

   ☐ medically required hand-held assistive device is necessary for ambulation

4. Sit (with normal breaks) for a total of—

   ☐ less than about 6 hours in an 8-hour workday
   ☐ about 6 hours in an 8-hour workday

   ☐ must periodically alternate sitting and standing to relieve pain or discomfort. (If checked, explain in 6.)

5. Push and/or pull (including operation of hand and/or foot controls)—

   ☐ unlimited, other than as shown for lift and/or carry
   ☐ limited in **upper** extremities (describe nature and degree)
   ☐ limited in **lower** extremities (describe nature and degree)

6. Explain how and why the evidence supports your conclusions in item 1 through 5. Cite the specific facts upon which your conclusions are based.

6. Continue (NOTE: MAKE ADDITIONAL COMMENTS IN SECTION IV)

B. POSTURAL LIMITATIONS

☐ None established. (Proceed to section C.)

	Frequently	Occasionally	Never
1. Climbing—ramp/stairs —ladder/rope/scaffolds	☐	☐	☐
2. Balancing	☐	☐	☐
3. Stooping	☐	☐	☐
4. Kneeling	☐	☐	☐
5. Crouching	☐	☐	☐
6. Crawling	☐	☐	☐

7. When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

C. MANIPULATIVE LIMITATIONS

☐ None established. (Proceed to section D.)

	LIMITED	UNLIMITED
1. Reaching all directions (including overhead)	☐	☐
2. Handling (gross manipulation)	☐	☐
3. Fingering (fine manipulation)	☐	☐
4. Feeling (skin receptors)	☐	☐

5. Describe how the activities checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in item 1 through 4. Cite the specific facts upon which your conclusions are based.

D. VISUAL LIMITATIONS

☐ None established. (Proceed to section E.)

	LIMITED	UNLIMITED
1. Near acuity	☐	☐
2. Far acuity	☐	☐
3. Depth perception	☐	☐
4. Accommodation	☐	☐
5. Color vision	☐	☐
6. Field of vision	☐	☐

7. Describe how the faculties checked "limited" are impaired. Also explain how and why the evidence supports your conclusions in item 1 through 6. Cite the specific facts upon which your conclusions are based.

E. COMMUNICATIVE LIMITATIONS

☐ None established. (Proceed to section F.)

	LIMITED	UNLIMITED
1. Hearing	☐	☐
2. Speaking	☐	☐

3. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 and 2. Cite the specific facts upon which your conclusions are based.

F. ENVIRONMENTAL LIMITATIONS

☐ None established. (Proceed to section II.)

	UNLIMITED	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
1. Extreme cold	☐	☐	☐	☐
2. Extreme heat	☐	☐	☐	☐
3. Wetness	☐	☐	☐	☐
4. Humidity	☐	☐	☐	☐
5. Noise	☐	☐	☐	☐
6. Vibration	☐	☐	☐	☐
7. Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
8. Hazards (machinery, heights, etc.)	☐	☐	☐	☐

9. Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions in items 1 through 8. Cite the specific facts upon which your conclusions are based.

9. Continue (NOTE: MAKE ADDITIONAL COMMENTS IN SECTION IV)

II. SYMPTOMS

For symptoms alleged by the claimant to produce physical limitations, and for which the following have not previously been addressed in section I, discuss whether:

A. The symptom(s) is attributable, in your judgment, to a medically determinable impairment.

B. The severity or duration of the symptom(s), in your judgment, is disproportionate to the expected severity or expected duration on the basis of the claimant's medically determinable impairment(s).

C. The severity of the symptom(s) and its alleged effect on function is consistent, in your judgment, with the total medical and nonmedical evidence, including statements by the claimant and others, observations regarding activities of daily living, and alterations of usual behavior or habits.

III. TREATING OR EXAMINING SOURCE STATEMENT(S)

A. Is a treating or examining source statement(s) regarding the claimant's physical capacities in file?

☐ Yes

☐ No (Includes situations in which there was no source or when the source(s) did not provide a statement regarding the claimant's physical capacities.)

B. If yes, are there treating/examining source conclusions about the claimant's limitations or restrictions which are significantly different from your findings?

☐ Yes

☐ No

C. If yes, explain why those conclusions are not supported by the evidence in file. (Cite the source's name and the statement date.)

IV. ADDITIONAL COMMENTS:

MEDICAL CONSULTANT'S SIGNATURE:	MEDICAL CONSULTANT'S CODE:	DATE:

★U.S.GPO:1993-0-339-454